



Facility Name & ID Number Litchfield Healthcare Center

# 0045753 Report Period Beginning: 01/01/08 Ending: 12/31/08

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds N/A

	1	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1	<u>26</u>	Skilled (SNF)	<u>26</u>	<u>9,516</u>	1
2		Skilled Pediatric (SNF/PED)			2
3	<u>97</u>	Intermediate (ICF)	<u>97</u>	<u>35,502</u>	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	<u>123</u>	TOTALS	<u>123</u>	<u>45,018</u>	7

B. Census-For the entire report period.

	1 Level of Care	2 3 4 5 Patient Days by Level of Care and Primary Source of Payment				
		Medicaid Recipient	Private Pay	Other	Total	
8	SNF	<u>410</u>	<u>379</u>	<u>4,917</u>	<u>5,706</u>	8
9	SNF/PED					9
10	ICF	<u>20,416</u>	<u>6,338</u>	<u>103</u>	<u>26,857</u>	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	<u>20,826</u>	<u>6,717</u>	<u>5,020</u>	<u>32,563</u>	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 72.33%

D. How many bed-hold days during this year were paid by the Department? 0 (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients. (E.g., day care, "meals on wheels", outpatient therapy)

None

F. Does the facility maintain a daily midnight census? Yes

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?  
 YES  NO  Note: Non-allowable costs have been eliminated in Schedule V, Column 7.

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?  
 YES  NO

I. On what date did you start providing long term care at this location?  
 Date started 01/01/1992

J. Was the facility purchased or leased after January 1, 1978?  
 YES  Date 01/01/1992 NO

K. Was the facility certified for Medicare during the reporting year?  
 YES  NO  If YES, enter number of beds certified 26 and days of care provided 4,857

Medicare Intermediary Wisconsin Physicians Service

IV. ACCOUNTING BASIS

ACCRAUAL  MODIFIED CASH\*  CASH\*

Is your fiscal year identical to your tax year? YES  NO

Tax Year: 12/31/08 Fiscal Year: 12/31/08

\* All facilities other than governmental must report on the accrual basis.

Facility Name & ID Number Litchfield Healthcare Center # 0045753 Report Period Beginning: 01/01/08 Ending: 12/31/08

**V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)**

	Operating Expenses	Costs Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7**	Adjusted Total 8	FOR BHF USE ONLY	
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10
	<b>A. General Services</b>										
1	Dietary	181,967	16,037	6,547	204,551		204,551	204,551			1
2	Food Purchase		161,582		161,582		161,582	161,582			2
3	Housekeeping	136,005	23,714		159,719		159,719	159,719			3
4	Laundry	56,538	5,037		61,575		61,575	61,575			4
5	Heat and Other Utilities			146,750	146,750		146,750	146,750			5
6	Maintenance	57,448	10,195	88,545	156,188		156,188	156,188			6
7	Other (specify):*										7
8	<b>TOTAL General Services</b>	431,958	216,565	241,842	890,365		890,365	890,365			8
	<b>B. Health Care and Programs</b>										
9	Medical Director			40,500	40,500		40,500	40,500			9
10	Nursing and Medical Records	1,547,346	122,683	7,365	1,677,394		1,677,394	1,677,394			10
10a	Therapy	421,619	7,509	17,991	447,119		447,119	447,119			10a
11	Activities	62,272	5,206	769	68,247		68,247	68,247			11
12	Social Services	33,058		4,230	37,288		37,288	37,288			12
13	CNA Training										13
14	Program Transportation										14
15	Other (specify):*										15
16	<b>TOTAL Health Care and Programs</b>	2,064,295	135,398	70,855	2,270,548		2,270,548	2,270,548			16
	<b>C. General Administration</b>										
17	Administrative	67,252		229,078	296,330		296,330	296,330			17
18	Directors Fees										18
19	Professional Services			84,600	84,600		84,600	84,600			19
20	Dues, Fees, Subscriptions & Promotions			7,117	7,117		7,117	7,117			20
21	Clerical & General Office Expenses	121,165	9,709	52,073	182,947		182,947	182,947			21
22	Employee Benefits & Payroll Taxes			545,714	545,714		545,714	545,714			22
23	Inservice Training & Education										23
24	Travel and Seminar			56,630	56,630		56,630	(56,630)			24
25	Other Admin. Staff Transportation			6,193	6,193		6,193	6,193			25
26	Insurance-Prop.Liab.Malpractice			12,071	12,071		12,071	12,071			26
27	Other (specify):*										27
28	<b>TOTAL General Administration</b>	188,417	9,709	993,476	1,191,602		1,191,602	(56,630)	1,134,972		28
29	<b>TOTAL Operating Expense (sum of lines 8, 16 &amp; 28)</b>	2,684,670	361,672	1,306,173	4,352,515		4,352,515	(56,630)	4,295,885		29

\*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds \$1000.

SEE ACCOUNTANTS' COMPILATION REPORT

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Facility Name & ID Number Litchfield Healthcare Center

#0045753

Report Period Beginning:

01/01/08

Ending:

12/31/08

## V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7**	Adjusted Total 8	FOR BHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	<b>D. Ownership</b>											
30	Depreciation			34,152	34,152		34,152	39,440	73,592			30
31	Amortization of Pre-Op. & Org.											31
32	Interest											32
33	Real Estate Taxes			77,268	77,268		77,268		77,268			33
34	Rent-Facility & Grounds			152,418	152,418		152,418		152,418			34
35	Rent-Equipment & Vehicles			8,271	8,271		8,271		8,271			35
36	Other (specify):*											36
37	<b>TOTAL Ownership</b>			272,109	272,109		272,109	39,440	311,549			37
	<b>Ancillary Expense</b>											
	<b>E. Special Cost Centers</b>											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		141,877	20	141,897		141,897		141,897			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			66,420	66,420		66,420		66,420			42
43	Other (specify):* <b>Non-allowable cost</b>	30,900		160,795	191,695		191,695	(191,695)				43
44	<b>TOTAL Special Cost Centers</b>	30,900	141,877	227,235	400,012		400,012	(191,695)	208,317			44
45	<b>GRAND TOTAL COST</b> (sum of lines 29, 37 & 44)	2,715,570	503,549	1,805,517	5,024,636		5,024,636	(208,885)	4,815,751			45

\*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds \$1000.

\*\*See schedule of adjustments attached at end of cost report.

SEE ACCOUNTANTS' COMPILATION REPORT

**VI. ADJUSTMENT DETAIL**

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7.

In column 2 below, reference the line on which the particular cost was included. (See instructions.)

		1	2	3	
	NON-ALLOWABLE EXPENSES	Amount	Refer- ence	BHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms	(12,165)	43		5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	39,440	30		9
10	Interest and Other Investment Income				10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax				13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties	(650)	43		18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(91,631)	43		24
25	Fund Raising, Advertising and Promotional	(1,019)	43		25
	Income Taxes and Illinois Personal				
26	Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule See Page 5A	(142,860)			29
30	<b>SUBTOTAL (A): (Sum of lines 1-29)</b>	\$ (208,885)		\$	30

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1	2	
		Amount	Reference	
31	Non-Paid Workers-Attach Schedule*	\$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)			34
35	Other- Attach Schedule			35
36	<b>SUBTOTAL (B): (sum of lines 31-35)</b>	\$		36
	(sum of SUBTOTALS			
37	<b>TOTAL ADJUSTMENTS (A) and (B) )</b>	\$ (208,885)		37

\*These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1	2	3	4	
		Yes	No	Amount	Reference	
38	Medically Necessary Transport.		x	\$		38
39						39
40	Gift and Coffee Shops		x			40
41	Barber and Beauty Shops		x			41
42	Laboratory and Radiology		x			42
43	Prescription Drugs		x			43
44						44
45	Other-Attach Schedule		x			45
46	Other-Attach Schedule		x			46
47	<b>TOTAL (C): (sum of lines 38-46)</b>			\$		47

BHF USE ONLY							
48		49		50		51	

SEE ACCOUNTANTS' COMPILATION REPORT

## Litchfield Healthcare Center

ID# 0045753

Report Period Beginning: 01/01/08

Ending: 12/31/08

Sch. V Line

NON-ALLOWABLE EXPENSES		Amount	Reference	Sch. V Line
1	Nonallowable marketing events	\$ (18,718)	43	1
2	Disallow Lab exp	(30,979)	43	2
3	Disallow X-Ray exp	(5,319)	43	3
4	Marketing Salary Offset	(30,900)	43	4
5	Disallow Travel & Seminar expense	(56,630)	24	5
6	Disallow Misc Receipts	(314)	43	6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	<b>Total</b>	(142,860)		49

SEE ACCOUNTANTS' COMPILATION REPORT

## STATE OF ILLINOIS

Summary A

Facility Name & ID Number Litchfield Healthcare Center# 0045753

Report Period Beginning:

01/01/08

Ending:

12/31/08

## SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Operating Expenses	PAGES	PAGE	SUMMARY										
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS	
													(to Sch V, col.7)	
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	0	0	0	0	0	0	0	0	0	0	0	0	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	0	0	0	0	0	0	0	0	0	0	0	5
6	Maintenance	0	0	0	0	0	0	0	0	0	0	0	0	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	<b>TOTAL General Services</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>8</b>
	<b>B. Health Care and Programs</b>													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	0	0	0	0	0	0	0	0	0	0	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	CNA Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	<b>TOTAL Health Care and Programs</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>16</b>
	<b>C. General Administration</b>													
17	Administrative	0	0	0	0	0	0	0	0	0	0	0	0	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	0	0	0	0	0	0	0	0	0	0	0	19
20	Fees, Subscriptions & Promotions	0	0	0	0	0	0	0	0	0	0	0	0	20
21	Clerical & General Office Expenses	0	0	0	0	0	0	0	0	0	0	0	0	21
22	Employee Benefits & Payroll Taxes	0	0	0	0	0	0	0	0	0	0	0	0	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	(56,630)	0	0	0	0	0	0	0	0	0	0	(56,630)	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	0	0	0	0	0	0	0	0	0	0	0	0	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	<b>TOTAL General Administration</b>	<b>(56,630)</b>	<b>0</b>	<b>(56,630)</b>	<b>28</b>									
29	<b>TOTAL Operating Expense</b> (sum of lines 8,16 & 28)	<b>(56,630)</b>	<b>0</b>	<b>(56,630)</b>	<b>29</b>									



**VII. RELATED PARTIES**

**A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.**

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
Family Senior Care	100	LaSalle Healthcare Center	LaSalle	Family Senior Care	North Miami, FL	Managed Care

**B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth.**  YES  NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization		
1	V	N/A	\$			\$	\$	1
2	V							2
3	V							3
4	V							4
5	V							5
6	V							6
7	V							7
8	V							8
9	V							9
10	V							10
11	V							11
12	V							12
13	V							13
14	<b>Total</b>		\$			\$	\$ *	14

\* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number Litchfield Healthcare Center # 0045753 Report Period Beginning: 01/01/08 Ending: 12/31/08

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

**NOTE: ALL owners ( even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.**

	1 Name	2 Title	3 Function	4 Ownership Interest	5 Compensation Received From Other Nursing Homes*	6 Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		7 Compensation Included in Costs for this Reporting Period**		8 Schedule V. Line & Column Reference
						Hours	Percent	Description	Amount	
1	N/A								\$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13								TOTAL	\$	13

\* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

\*\* This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Litchfield Healthcare Center

# 0045753 Report Period Beginning: 01/01/08 Ending: 12/31/08

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES  NO

Name of Related Organization \_\_\_\_\_  
 Street Address \_\_\_\_\_  
 City / State / Zip Code \_\_\_\_\_  
 Phone Number ( ) \_\_\_\_\_  
 Fax Number ( ) \_\_\_\_\_

B. Show the allocation of costs below. If necessary, please attach worksheets.

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1					\$	\$		\$	1
2	N/A								2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS				\$	\$		\$	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number

Litchfield Healthcare Center

# 0045753

Report Period Beginning:

01/01/08

Ending:

12/31/08

**IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE**

**A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)**

1	2	3	4	5	6	7	8	9	10											
										Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense
											YES	NO				Original	Balance			
<b>A. Directly Facility Related</b>																				
<b>Long-Term</b>																				
1																				
2	N/A																			
3																				
4																				
5																				
<b>Working Capital</b>																				
6																				
7																				
8																				
9	<b>TOTAL Facility Related</b>																			
<b>B. Non-Facility Related*</b>																				
10																				
11																				
12																				
13																				
14	<b>TOTAL Non-Facility Related</b>																			
15	<b>TOTALS (line 9+line14)</b>																			

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V.      \$ None                      Line # N/A

\* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7.  
(See instructions.)

SEE ACCOUNTANTS' COMPILATION REPORT

\*\* If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2.  
(See instructions.)

**IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)**

**B. Real Estate Taxes**

**Important**, please see the next worksheet, "RE\_Tax". The real estate tax statement and bill must accompany the cost report.

1. Real Estate Tax accrual used on 2007 report.		\$	<b>44,800</b>	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)	2007	\$	<b>78,758</b>	2
3. Under or (over) accrual (line 2 minus line 1).		\$	<b>33,958</b>	3
4. Real Estate Tax accrual used for 2008 report. (Detail and explain your calculation of this accrual on the lines below.)		\$	<b>7,618</b>	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. <b>(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)</b>		\$		5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund.			<b>35,692</b>	
<b>TOTAL REFUND</b> \$ _____ For _____ Tax Year. <b>(Attach a copy of the real estate tax appeal board's decision.)</b>		\$		6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		\$	<b>77,268</b>	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:	2003	<b>65,253</b>	8
	2004	<b>70,095</b>	9
	2005	<b>72,691</b>	10
	2006	<b>74,962</b>	11
	2007	<b>78,758</b>	12

Accrual is based on prior year expense.

<b>FOR BHF USE ONLY</b>			
13	FROM R. E. TAX STATEMENT FOR 2007	\$	13
14	PLUS APPEAL COST FROM LINE 5	\$	14
15	LESS REFUND FROM LINE 6	\$	15
16	AMOUNT TO USE FOR RATE CALCULATION	\$	16

**NOTES:**

1. Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.
2. If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity. **This denial must be no more than four years old at the time the cost report is filed.**

SEE ACCOUNTANTS' COMPILATION REPORT

**IMPORTANT NOTICE**

**TO:** Long Term Care Facilities with Real Estate Tax Rates **RE:** 2007 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2007 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2007.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2007 real estate tax bill to Healthcare and Family Services, Bureau of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

**Please send these items in with your completed 2008 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed.** If you have any questions, please call the Bureau of Health Finance at (217) 782-1630.

**2007 LONG TERM CARE REAL ESTATE TAX STATEMENT**

FACILITY NAME Litchfield Healthcare Center COUNTY Montgomery

FACILITY IDPH LICENSE NUMBER 0045753

CONTACT PERSON REGARDING THIS REPORT Theodore Duay

TELEPHONE (305) 892-1790 FAX #: (305) 538-2699

**A. Summary of Real Estate Tax Cost**

Enter the tax index number and real estate tax assessed for 2007 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2007.

(A)	(B)	(C)	(D)
<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	<u>Tax Applicable to Nursing Home</u>
1. <u>10-34-302-012</u>	<u>PT W 1/2 SW Lands Corp Limits</u>	\$ <u>74,997.86</u>	\$ <u>74,997.86</u>
2. <u>10-34-302-011</u>	<u>PT W 1/2 SW Lands Corp Limits</u>	\$ <u>3,760.06</u>	\$ <u>3,760.06</u>
3. _____	_____	\$ _____	\$ _____
4. _____	_____	\$ _____	\$ _____
5. _____	_____	\$ _____	\$ _____
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
<b>TOTALS</b>		\$ <u>78,757.92</u>	\$ <u>78,757.92</u>

**B. Real Estate Tax Cost Allocations**

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services?        YES        X        NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

**C. Tax Bills**

Attach a copy of the original 2007 tax bills which were listed in Section A to this statement. Be sure to use the 2007 tax bill which is normally paid during 2008.

**PLEASE NOTE:** Payment information from the Internet or otherwise is not considered acceptable tax bill documentation. Facilities located in Cook County are required to provide copies of their original **second installment** tax bill.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Litchfield Healthcare Center

# 0045753

Report Period Beginning:

01/01/08

Ending:

12/31/08

**X. BUILDING AND GENERAL INFORMATION:**

A. Square Feet: 35,189 B. General Construction Type: Exterior MASONRY Frame STEEL Number of Stories 2

C. Does the Operating Entity?  (a) Own the Facility  (b) Rent from a Related Organization.  (c) Rent from Completely Unrelated Organization.  
(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity?  (a) Own the Equipment  (b) Rent equipment from a Related Organization.  (c) Rent equipment from Completely Unrelated Organization.  
(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, CNA training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

N/A

F. Does this cost report reflect any organization or pre-operating costs which are being amortized?  YES  NO  
If so, please complete the following:

1. Total Amount Incurred: N/A 2. Number of Years Over Which it is Being Amortized: N/A

3. Current Period Amortization: N/A 4. Dates Incurred: N/A

Nature of Costs:

(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

**XI. OWNERSHIP COSTS:**

A. Land.

	1	2	3	4	
	Use	Square Feet	Year Acquired	Cost	
1	<u>N/A</u>			\$	1
2					2
3	TOTALS			\$	3

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Litchfield Healthcare Center# 0045753

Report Period Beginning:

01/01/08

Ending:

12/31/08**XI. OWNERSHIP COSTS (continued)****B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.**

	1	2	3	4	5	6	7	8	9		
	Beds*	FOR BHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
4					\$	\$		\$	\$	\$	4
5											5
6											6
7											7
8											8
	<b>Improvement Type**</b>										
9	Building Improvement		1982		2,131		20			2,131	9
10	Building Improvement		1983		2,986		20			2,986	10
11	Building Improvement		1984		53,393		20			53,393	11
12	Building Improvement		1985		55,378		20			55,378	12
13	Building Improvement		1986		2,920		20			2,920	13
14	Building Improvement		1989		5,059		20	253	253	4,763	14
15	Building Improvement		1990		3,677		20	184	184	3,322	15
16	Building Improvement		1991		3,100		20	155	155	2,779	16
17	Building Improvement		1992		10,816		20	541	541	8,982	17
18	Building Improvement		1993		14,559		20			14,559	18
19	Building Improvement		1994		94,548		20	4,727	4,727	44,729	19
20	Windows		1997		599		20	30	30	361	20
21	Rooftop A/C Unit		1996		8,850		20	443	443	5,371	21
22	Painting		1996		5,000		20	250	250	3,142	22
23	Air Conditioner		1997		3,416		20	171	171	1,962	23
24	Fire Alarm System		1997		732		20	37	37	415	24
25	Ground Sign		1997		2,900		20	145	145	1,700	25
26	Paving/Sidewalks Repair		1998		950		15	63	63	690	26
27	HVAC		1998		10,764		20	538	538	5,873	27
28	HVAC - Condensor Replacement Unit		1998		4,275		15	285	285	2,921	28
29	Carpet		1998		6,276		5			6,276	29
30	Landscaping		1998		6,222		20	311	311	5,253	30
31	Handicap Ramp		1998		950		20	48	48	513	31
32	Fire Alarm System		1999		6,809		10	680	680	6,809	32
33	Replace 2 AO Smith Water		1999		12,500		10	1,250	1,250	12,292	33
34	6: Islandaire A/C Heaters		1999		6,267		5			6,267	34
35											35
36											36

\*Total beds on this schedule must agree with page 2.

\*\*Improvement type must be detailed in order for the cost report to be considered complete.

See Page 12A, Line 70 for total

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name &amp; ID Number Litchfield Healthcare Center

# 0045753

Report Period Beginning:

01/01/08

Ending:

12/31/08

## XI. OWNERSHIP COSTS (continued)

## B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
37	Condensor & Coil Repair W/N Freezer	2000	\$ 3,800	\$	15	\$ 253	\$ 253	\$ 2,341	37
38	Electric Transfer Switch Installed	2000	2,675		10	268	268	2,501	38
39	F/A Smoke Detection Inspect	2000	782		10	78	78	676	39
40	2: Islandaire Heat/Cool Units	2000	2,168		10	217	217	1,917	40
41	Architect Service F/A Systems	2000	16,988		10	1,699	1,699	14,441	41
42	10: 12 BTU HVAC Units	2000	11,038		10	1,104	1,104	7,666	42
43	Architect Fees, FA System	2000	8,612		15	574	574	6,027	43
44	Water Heater - Laundry	2000	5,400		10	540	540	4,410	44
45	Architect Retainage & Reimbursement	2000	5,238		10	524	524	4,279	45
46	Replace Fire Alarm System App. No. 1	2000	85,313		10	8,531	8,531	69,670	46
47	Replace Fire Alarm System App. No. 2	2000	45,074		10	4,507	4,507	36,807	47
48	Architect Fee, Reimburse, 11%	2001	3,379		10	338	338	2,732	48
49	Construction Fee, Fire Alarm, App #3 (2.5%)	2001	3,343		10	334	334	2,701	49
50	7: Islandaire HVAC Units	2001	7,140		15	476	476	3,626	50
51	Use Tax - 7 : Islandaire HVAC Units	2001	446		15	30	30	237	51
52	R Concrete, Employee Entrance	2001	1,520		15	101	101	767	52
53	R Concrete, Emergency Entrance	2001	1,635		15	109	109	827	53
54	Repairs Roof & Gutters, Pat Rm	2001	3,649		10	365	365	2,676	54
55	Nurse Call System Upgrade	2001	4,350		10	435	435	3,118	55
56									56
57	Service, Nurse Call System	2002	830		10	83	83	595	57
58	Domestic W/H Investigation	2002	2,100		10	210	210	1,540	58
59	Architect Fees - Blue Prints	2002	900		15	60	60	415	59
60	2: Fire Rated Exit Device	2002	6,753		10	675	675	4,444	60
61	Replace Doors & Frams	2002	16,358		15	1,091	1,091	7,181	61
62	Floor Prep Base Tile Work	2002	15,246		15	1,016	1,016	6,774	62
63	Plumbing / Kitchen	2002	5,627		20	281	281	1,874	63
64	Repairs Wall & Door - Kitchen	2002	9,664		15	644	644	4,294	64
65	Electrical Work - Kitchen	2002	1,063		20	53	53	354	65
66	Ext Reclamation / Concrete Patch	2002	2,194		15	146	146	974	66
67	Horns & Strobes Instl. - F/A System	2002	2,850		10	285	285	1,876	67
68	HVAC RTU - 2nd Floor Hall N Station	2002	6,695		15	446	446	2,863	68
69									69
70	TOTAL (lines 4 thru 69)		\$ 607,907	\$		\$ 35,584	\$ 35,584	\$ 456,390	70

SEE ACCOUNTANTS' COMPILATION REPORT

\*\*Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name &amp; ID Number Litchfield Healthcare Center

# 0045753

Report Period Beginning:

01/01/08

Ending:

12/31/08

## XI. OWNERSHIP COSTS (continued)

## B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	<b>Totals from Page 12A, Carried Forward</b>		\$ 607,907	\$		\$ 35,584	\$ 35,584	\$ 456,390	1
2	HVAC RTU 1st Floor TV Room	2002	7,102		15	473	473	3,036	2
3	Architect Fees / Convert Beds	2002	6,230		15	415	415	2,663	3
4	Architect Fees Pat Rm Wardrobes	2002	387		15			387	4
5									5
6	WanderGuard System Install	2003	688		10	69	69	402	6
7	Repairs WanderGuard Sys	2003	934		10	93	93	551	7
8	2: Door Closer - WanderGuard	2003	1,067		10	107	107	615	8
9	Auto Fire Protection	2003	2,600		10	260	260	1,473	9
10	WanderGuard System Install	2003	6,651		10	665	665	3,824	10
11	WanderGuard System Install	2003	30,049		10	3,005	3,005	17,529	11
12	Replace 848: ceiling tiles	2003	5,168		15	345	345	1,926	12
13	Architect & Engineering Fee Wardr	2003	444		15	30	30	170	13
14	Use Tax Architect & Engineering Fee Wardr	2003	30		15	2	2	11	14
15	Replace HVSRTU #4	2003	7,528		15	502	502	2,761	15
16	Ceiling Mounted Exhaust Fan	2003	5,817		10	582	582	3,201	16
17	2 Ton Condensing Unit Air Hand	2003	8,047		15	536	536	2,948	17
18	2: 5 Ton A/R Unit Kitchen	2003	16,728		10	1,673	1,673	9,201	18
19	Lumber - Gazebo	2003	791		10	79	79	415	19
20	Rocks, 8 Ton Dirt - Gazebo	2003	123		10	12	12	63	20
21									21
22	Double Roof Instl - Gazebo	2004	3,122		10	312	312	1,586	22
23	6: Heat/Cool Units - Res Rms	2004	5,687		5	1,137	1,137	5,591	23
24	Use Tax - 6: Heat/Cool Units - Res	2004	384		5	77	77	378	24
25	Water Cooler, Surface Mount	2004	509		10	51	51	238	25
26	Use Tax - Water Cooler, Surface Mount	2004	29		10	3	3	14	26
27	Water Softner System	2004	3,163		10	316	316	1,343	27
28	Repair Nurse Call	2004	1,105		10	111	111	462	28
29	2: Heat/Cool Units	2004	1,940		10	194	194	873	29
30	Use Tax - 2: Heat/Cool Units	2004	131		10	13	13	59	30
31									31
32									32
33									33
34	<b>TOTAL (lines 1 thru 33)</b>		\$ 724,361	\$		\$ 46,646	\$ 46,646	\$ 518,110	34

SEE ACCOUNTANTS' COMPILATION REPORT

\*\*Improvement type must be detailed in order for the cost report to be considered complete.

**XI. OWNERSHIP COSTS (continued)**

**B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.**

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	<b>Totals from Page 12B, Carried Forward</b>		\$ 724,361	\$		\$ 46,646	\$ 46,646	\$ 518,110	1
2	Maglock - Wanderguard	2005	738		10	74	74	222	2
3	Fire System - Hood/Kitchen	2005	68		10	7	7	20	3
4	Fire Suppression Hood	2005	2,065		10	207	207	620	4
5									5
6	Window - Add'l Ramp	2005	2,113		15	141	141	492	6
7	Exterior concrete work- sidewalks and curbing	2005	34,881		15	2,325	2,325	8,142	7
8	Window - Front Lobby	2005	3,879		15	259	259	905	8
9	Major Landscaping Improvements	2005	3,322		5	738	738	2,472	9
10									10
11	HVAC	2006	3,320		15	221	221	553	11
12									12
13	Telephone System	2008	9,450		20	236	236	236	13
14	Roof Repair	2008	95,233		20	2,381	2,381	2,381	14
15	Fire System	2008	4,950		20	124	124	124	15
16	Elevator Repairs	2008	16,881		20	422	422	422	16
17	Additional Sprinklers	2008	18,690		20	467	467	467	17
18									18
19									19
20	<b>Current Year Booked Depreciation</b>			19,476			(19,476)		20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	<b>TOTAL (lines 1 thru 33)</b>		\$ 919,951	\$ 19,476		\$ 54,248	\$ 34,772	\$ 535,166	34

SEE ACCOUNTANTS' COMPILATION REPORT

\*\*Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Litchfield Healthcare Center

# 0045753

Report Period Beginning:

01/01/08

Ending:

12/31/08

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	\$ 215,984	\$ 14,676	\$ 15,471	\$ 795	3-15	\$ 170,281	71
72	Current Year Purchases	77,465		3,873	3,873	10	3,873	72
73	Fully Depreciated Assets	349,248					349,248	73
74								74
75	TOTALS	\$ 642,697	\$ 14,676	\$ 19,344	\$ 4,668		\$ 523,402	75

D. Vehicle Depreciation (See instructions.)\*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76	N/A			\$	\$	\$	\$		\$	76
77										77
78										78
79										79
80	TOTALS			\$	\$	\$	\$		\$	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount	
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	\$ 1,562,648	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 34,152	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 73,592	83**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 39,440	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 1,058,568	85

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86		\$	\$	\$	86
87	N/A				87
88					88
89					89
90					90
91	TOTALS	\$	\$	\$	91

G. Construction-in-Progress

	Description	Cost	
92		\$	92
93	N/A		93
94			94
95		\$	95

\* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

\*\* This must agree with Schedule V line 30, column 8.

SEE ACCOUNTANTS' COMPILATION REPORT



**XIII. EXPENSES RELATING TO CERTIFIED NURSE AIDE (CNA) TRAINING PROGRAMS (See instructions.)**

**A. TYPE OF TRAINING PROGRAM (If CNAs are trained in another facility program, attach a schedule listing the facility name, address and cost per CNA trained in that facility.)**

<p><b>1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD?</b></p> <p><input type="checkbox"/> YES      <input checked="" type="checkbox"/> NO</p> <p>It is the policy of this facility to only hire certified nurses aides. If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.</p>	<p><b>2. CLASSROOM PORTION:</b></p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>COMMUNITY COLLEGE <input type="checkbox"/></p> <p>HOURS PER CNA _____</p>	<p><b>3. CLINICAL PORTION:</b></p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>HOURS PER CNA _____</p>
--	---	--

**B. EXPENSES**

**ALLOCATION OF COSTS (d)**

		Facility		3	4
		1	2		
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	\$	\$	\$	\$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	CNA Competency Tests				
9	<b>TOTALS</b>	\$	\$	\$	\$
10	<b>SUM OF line 9, col. 1 and 2 (e)</b>	\$			

**C. CONTRACTUAL INCOME**

In the box below record the amount of income your facility received training CNAs from other facilities.

\$

**D. NUMBER OF CNAs TRAINED**

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
<b>TOTAL TRAINED</b>	

- (a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
- (b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
- (c) For in-house training programs only. Do not include fringe benefits.
- (d) Allocate based on if the CNA is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own CNAs.

- (e) The total amount of Drop-out and Completed Costs for your own CNAs must agree with Sch. V, line 13, col. 8.
  - (f) Attach a schedule of the facility names and addresses of those facilities for which you trained CNAs.
- SEE ACCOUNTANTS' COMPILATION REPORT**

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist	10A (1,3)	5260 hrs	\$ 171,035		\$	1,632	5,260	\$ 172,667	1
2	Licensed Speech and Language Development Therapist	10A(1,3)	1551 hrs	55,214			1,118	1,551	56,332	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	10A(1,2,3)	5261 hrs	195,371			4,759	5,261	200,130	4
5	Physician Care	39(3)	visits		1	20		1	20	5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39(2)	# of prescrpts				131,975		131,975	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify): _____									12
13	Other (specify): <u>Oxygen&amp;Ambulance</u>	39(2)					9,902		9,902	13
14	<b>TOTAL</b>			\$ 421,619	1	\$ 20	\$ 149,386	12,073	\$ 571,025	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as CNAs, who help with the above activities should not be listed on this schedule.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Litchfield Healthcare Center

# 0045753

Report Period Beginning: 01/01/08

Ending:

12/31/08

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/08

(last day of reporting year)

This report must be completed even if financial statements are attached.

		1	2	
		Operating	After Consolidation*	
	<b>A. Current Assets</b>			
1	Cash on Hand and in Banks	\$ 2,800	\$ 2,800	1
2	Cash-Patient Deposits	268	268	2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 206,102 )	795,791	795,791	3
4	Supply Inventory (priced at )			4
5	Short-Term Investments			5
6	Prepaid Insurance	138,902	138,902	6
7	Other Prepaid Expenses	42,148	42,148	7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): Due to/from Leasehold	498	498	9
10	<b>TOTAL Current Assets (sum of lines 1 thru 9)</b>	\$ 980,407	\$ 980,407	10
	<b>B. Long-Term Assets</b>			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land			13
14	Buildings, at Historical Cost			14
15	Leasehold Improvements, at Historical Cost	367,819	919,951	15
16	Equipment, at Historical Cost	195,384	642,697	16
17	Accumulated Depreciation (book methods)	(184,378)	(1,058,568)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify):			23
24	<b>TOTAL Long-Term Assets (sum of lines 11 thru 23)</b>	\$ 378,825	\$ 504,080	24
25	<b>TOTAL ASSETS (sum of lines 10 and 24)</b>	\$ 1,359,232	\$ 1,484,487	25

		1	2	
		Operating	After Consolidation*	
	<b>C. Current Liabilities</b>			
26	Accounts Payable	\$ 515,057	\$ 515,057	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	121,775	121,775	30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)	7,618	7,618	32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	<b>Other Current Liabilities(specify):</b>			
36	See Schedule 17A	906,833	906,833	36
37	Due to/from Related Facilities	847,570	847,570	37
38	<b>TOTAL Current Liabilities (sum of lines 26 thru 37)</b>	\$ 2,398,853	\$ 2,398,853	38
	<b>D. Long-Term Liabilities</b>			
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	<b>Other Long-Term Liabilities(specify):</b>			
43	Worker's Comp Revolver - L/T	179,463	179,463	43
44				44
45	<b>TOTAL Long-Term Liabilities (sum of lines 39 thru 44)</b>	\$ 179,463	\$ 179,463	45
46	<b>TOTAL LIABILITIES (sum of lines 38 and 45)</b>	\$ 2,578,316	\$ 2,578,316	46
47	<b>TOTAL EQUITY(page 18, line 24)</b>	\$ (1,219,084)	\$ (1,093,829)	47
48	<b>TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)</b>	\$ 1,359,232	\$ 1,484,487	48

Litchfield Healthcare Center  
0045753  
12/31/2008

Schedule 17A

XV. BALANCE SHEET

Line 36: Other Current Liabilities (specify):

	<u>Operating</u>	<u>After Consolidation</u>
Garnishments	(532)	(532)
Miscellaneous Deductions	1,350	1,350
Accrued Unemployment	30,485	30,485
Accrued Employer Insurance	2,559	2,559
Accrued Self Funded Insurance	143,173	143,173
Accrued Insurance	364,136	364,136
Accrued 401(k) Company Matcl	1,653	1,653
Accrued Workers Compensatio	223,094	223,094
Accrued Provider Assessment	14,943	14,943
SAVA Accruals	70,277	70,277
Accrued Management Fees	178,695	178,695
	<u>1,029,833</u>	<u>1,029,833</u>

SEE ACCOUNTANTS' COMPILATION REPORT

**XVI. STATEMENT OF CHANGES IN EQUITY**

		<b>1 Total</b>	
<b>1</b>	<b>Balance at Beginning of Year, as Previously Reported</b>	\$ <b>(775,051)</b>	<b>1</b>
<b>2</b>	Restatements (describe):		<b>2</b>
<b>3</b>			<b>3</b>
<b>4</b>			<b>4</b>
<b>5</b>			<b>5</b>
<b>6</b>	<b>Balance at Beginning of Year, as Restated (sum of lines 1-5)</b>	\$ <b>(775,051)</b>	<b>6</b>
	<b>A. Additions (deductions):</b>		
<b>7</b>	NET Income (Loss) (from page 19, line 43)	(444,033)	<b>7</b>
<b>8</b>	Aquisitions of Pooled Companies		<b>8</b>
<b>9</b>	Proceeds from Sale of Stock		<b>9</b>
<b>10</b>	Stock Options Exercised		<b>10</b>
<b>11</b>	Contributions and Grants		<b>11</b>
<b>12</b>	Expenditures for Specific Purposes		<b>12</b>
<b>13</b>	Dividends Paid or Other Distributions to Owners	( )	<b>13</b>
<b>14</b>	Donated Property, Plant, and Equipment		<b>14</b>
<b>15</b>	Other (describe)		<b>15</b>
<b>16</b>	Other (describe)		<b>16</b>
<b>17</b>	<b>TOTAL Additions (deductions) (sum of lines 7-16)</b>	\$ <b>(444,033)</b>	<b>17</b>
	<b>B. Transfers (Itemize):</b>		
<b>18</b>			<b>18</b>
<b>19</b>			<b>19</b>
<b>20</b>			<b>20</b>
<b>21</b>			<b>21</b>
<b>22</b>			<b>22</b>
<b>23</b>	<b>TOTAL Transfers (sum of lines 18-22)</b>	\$	<b>23</b>
<b>24</b>	<b>BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)</b>	\$ <b>(1,219,084)</b>	<b>24</b> *

\* This must agree with page 17, line 47.

SEE ACCOUNTANTS' COMPILATION REPORT

**XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.**

**Note: This schedule should show gross revenue and expenses. Do not net revenue against expense**

1

	Revenue	Amount	
	<b>A. Inpatient Care</b>		
1	Gross Revenue -- All Levels of Care	\$ 3,700,335	1
2	Discounts and Allowances for all Levels	(97,829)	2
3	<b>SUBTOTAL Inpatient Care (line 1 minus line 2)</b>	\$ 3,602,506	3
	<b>B. Ancillary Revenue</b>		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	746,662	6
7	Oxygen	11,732	7
8	<b>SUBTOTAL Ancillary Revenue (lines 4 thru 7)</b>	\$ 758,394	8
	<b>C. Other Operating Revenue</b>		
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	189,922	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	9,405	19
20	Radiology and X-Ray	6,997	20
21	Other Medical Services	13,379	21
22	Laundry		22
23	<b>SUBTOTAL Other Operating Revenue (lines 9 thru 22)</b>	\$ 219,703	23
	<b>D. Non-Operating Revenue</b>		
24	Contributions		24
25	Interest and Other Investment Income***		25
26	<b>SUBTOTAL Non-Operating Revenue (lines 24 and 25)</b>	\$	26
	<b>E. Other Revenue (specify):****</b>		
27	<b>Settlement Income (Insurance, Legal, Etc.)</b>		27
28			28
28a			28a
29	<b>SUBTOTAL Other Revenue (lines 27, 28 and 28a)</b>	\$	29
30	<b>TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)</b>	\$ 4,580,603	30

2

	Expenses	Amount	
	<b>A. Operating Expenses</b>		
31	General Services	890,365	31
32	Health Care	2,270,548	32
33	General Administration	1,191,602	33
	<b>B. Capital Expense</b>		
34	Ownership	272,109	34
	<b>C. Ancillary Expense</b>		
35	Special Cost Centers	333,592	35
36	Provider Participation Fee	66,420	36
	<b>D. Other Expenses (specify):</b>		
37			37
38			38
39			39
40	<b>TOTAL EXPENSES (sum of lines 31 thru 39)*</b>	\$ 5,024,636	40
41	<b>Income before Income Taxes (line 30 minus line 40)**</b>	(444,033)	41
42	<b>Income Taxes</b>		42
43	<b>NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)</b>	\$ (444,033)	43

\* This must agree with page 4, line 45, column 4.

\*\* Does this agree with taxable income (loss) per Federal Income Tax Return? No If not, please attach a reconciliation.  
This entity files a consolidated tax return.

\*\*\* See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation. SEE ACCOUNTANTS' COMPILATION REPORT

\*\*\*\*Provide a detailed breakdown of "Other Revenue" on an attached sheet.

Facility Name & ID Number Litchfield Healthcare Center

# 0045753

Report Period Beginning:

01/01/08

Ending:

12/31/08

**XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)**

(This schedule must cover the entire reporting period.)

	1	2**	3	4		
	# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage		
1	Director of Nursing	1,784	2,000	\$ 83,667	\$ 41.83	1
2	Assistant Director of Nursing	1,840	2,000	36,835	18.42	2
3	Registered Nurses	3,175	4,016	97,219	24.21	3
4	Licensed Practical Nurses	18,048	21,696	445,352	20.53	4
5	CNAs & Orderlies	66,132	74,857	884,272	11.81	5
6	CNA Trainees	0	0			6
7	Licensed Therapist	11,343	12,072	421,619	34.93	7
8	Rehab/Therapy Aides					8
9	Activity Director	1,849	2,000	26,251	13.13	9
10	Activity Assistants	4,002	4,386	36,021	8.21	10
11	Social Service Workers	1,920	2,000	33,058	16.53	11
12	Dietician					12
13	Food Service Supervisor	1,680	2,000	31,411	15.71	13
14	Head Cook			0		14
15	Cook Helpers/Assistants	15,351	16,995	150,556	8.86	15
16	Dishwashers					16
17	Maintenance Workers	35,563	3,861	57,448	14.88	17
18	Housekeepers	13,700	14,903	136,005	9.13	18
19	Laundry	4,648	5,646	56,538	10.01	19
20	Administrator	1,624	2,000	67,252	33.63	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	6,314	8,905	121,165	13.61	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records					31
32	Other Health Care(specify)					32
33	Other(specify) <u>Marketing</u>	1,845	2,000	30,900	15.45	33
34	TOTAL (lines 1 - 33)	190,818	181,337	\$ 2,715,570 *	\$ 14.98	34

\* This total must agree with page 4, column 1, line 45.

\*\* See instructions.

**B. CONSULTANT SERVICES**

	1	2	3		
	Number of Hrs. Paid & Accrued	Total Consultant Cost for Reporting Period	Schedule V Line & Column Reference		
35	Dietary Consultant	Monthly	\$ 6,547	1(3)	35
36	Medical Director	Monthly	40,500	9(3)	36
37	Medical Records Consultant	10	552	10(3)	37
38	Nurse Consultant				38
39	Pharmacist Consultant	Monthly	6,813	10(3)	39
40	Physical Therapy Consultant	Monthly	17,991	10A(3)	40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant	13	769	11(3)	44
45	Social Service Consultant	73	4,230	12(2)	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	96	\$ 77,402		49

**C. CONTRACT NURSES**

	1	2	3		
	Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference		
50	Registered Nurses		\$		50
51	Licensed Practical Nurses	N/A			51
52	Certified Nurse Assistants/Aides				52
53	TOTAL (lines 50 - 52)		\$		53

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number **Litchfield Healthcare Center**

# **0045753**

Report Period Beginning: **01/01/08**

Ending: **12/31/08**

**XIX. SUPPORT SCHEDULES**

A. Administrative Salaries				D. Employee Benefits and Payroll Taxes				F. Dues, Fees, Subscriptions and Promotions			
Name	Function	Ownership %	Amount	Description	Amount	Description	Amount				
Mary Buffington	Administrator	0	\$ 67,252	Workers' Compensation Insurance	\$ 148,608	IDPH License Fee	\$ 1,990				
				Unemployment Compensation Insurance	16,842	Advertising: Employee Recruitment	0				
				FICA Taxes	207,741	Health Care Worker Background Check (Indicate # of checks performed <u>152</u> )	1,829				
				Employee Health Insurance	170,408	Patient Background Checks <u>148</u>	1,779				
				Employee Meals		Misc Licenses & Fees	920				
				Illinois Municipal Retirement Fund (IMRF)*		Misc Dues & Subscriptions	599				
				Employee Relations	2,115						
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			\$ 67,252								
B. Administrative - Other				E. Schedule of Non-Cash Compensation Paid to Owners or Employees				G. Schedule of Travel and Seminar**			
Description			Amount	Description			Amount	Description			Amount
Family Senior Care - Management Fees			\$ 229,078	N/A				Out-of-State Travel			\$
								N/A			
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)			\$ 229,078	TOTAL (agree to Schedule V, line 22, col.8)			\$ 545,714	TOTAL (agree to Sch. V, line 20, col. 8)			\$ 7,117
C. Professional Services				G. Schedule of Travel and Seminar**							
Vendor/Payee	Type		Amount	Description			Amount	Description			Amount
Ferry & Associates	Legal		\$ 697					In-State Travel			
Moore Stephens Lovelace	Accounting		1,800					N/A			
RSM McGladrey	Accounting		27,707								
Hamlin & Burton	Risk Management		1,063					Seminar Expense			
Payday USA	Payroll Processing		6,228					N/A			
Ivans Inc.	Data Processing		7,328								
IT Management	Computer Maint		31,827					Entertainment Expense			(
IT Management	Internet Services		7,950					(agree to Sch. V, line 24, col. 8)			
TOTAL (agree to Schedule V, line 19, column 3) (If total legal fees exceed \$5,000, attach copy of invoices.)			\$ 84,600	TOTAL			\$	TOTAL			\$

\* Attach copy of IMRF notifications  
SEE ACCOUNTANTS' COMPILATION REPORT

\*\*See instructions.

**XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).**

(See instructions.)

1	2	3	4	5	6	7	8	9	10	11	12	13								
													Amount of Expense Amortized Per Year							
													Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	FY2005	FY2006	FY2007	FY2008
1		\$		\$	\$	\$	\$	\$	\$	\$	\$	\$								
2																				
3																				
4	N/A																			
5																				
6																				
7																				
8																				
9																				
10																				
11																				
12																				
13																				
14																				
15																				
16																				
17																				
18																				
19																				
20	<b>TOTALS</b>	\$		\$	\$	\$	\$	\$	\$	\$	\$	\$								

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Litchfield Healthcare Center# 0045753

Report Period Beginning:

01/01/08

Ending:

12/31/08**XX. GENERAL INFORMATION:**

- (1) Are nursing employees (RN,LPN,NA) represented by a union? No
- (2) Are there any dues to nursing home associations included on the cost report? No  
If YES, give association name and amount. N/A
- (3) Did the nursing home make political contributions or payments to a political action organization? No If YES, have these costs been properly adjusted out of the cost report? N/A
- (4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? No If YES, what is the capacity? N/A
- (5) Have you properly capitalized all major repairs and equipment purchases? Yes  
What was the average life used for new equipment added during this period? 10 Yrs
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 7,675 Line 10(2)
- (7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? Yes If NO, attach a complete explanation.
- (8) Are you presently operating under a sale and leaseback arrangement? No  
If YES, give effective date of lease. N/A
- (9) Are you presently operating under a sublease agreement? YES X NO
- (10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES NO X If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over. N/A
- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. \$ 66,420  
This amount is to be recorded on line 42 of Schedule V.
- (12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? No If YES, attach an explanation of the allocation.

**SEE ACCOUNTANTS' COMPILATION REPORT**

- (13) Have costs for all supplies and services which are of the type that can be billed to the Department, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? Yes
- (14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? No For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.
- (15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. \$ N/A Has any meal income been offset against related costs? N/A Indicate the amount. \$ 0
- (16) Travel and Transportation
- a. Are there costs included for out-of-state travel? No  
If YES, attach a complete explanation.
- b. Do you have a separate contract with the Department to provide medical transportation for residents? No If YES, please indicate the amount of income earned from such a program during this reporting period. \$ N/A
- c. What percent of all travel expense relates to transportation of nurses and patients? 0
- d. Have vehicle usage logs been maintained? Adequate records have been maintained.
- e. Are all vehicles stored at the nursing home during the night and all other times when not in use? N/A
- f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? N/A
- g. Does the facility transport residents to and from day training? No**  
**Indicate the amount of income earned from providing such transportation during this reporting period. \$ N/A**
- (17) Has an audit been performed by an independent certified public accounting firm? NO  
Firm Name: N/A The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? N/A If no, please explain. N/A
- (18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? Yes
- (19) If total legal fees are in excess of \$5,000, have legal invoices and a summary of services performed been attached to this cost report? N/A  
Attach invoices and a summary of services for all architect and appraisal fees